FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0049718

Facility Name: Galena Stauss Nursing Home

Address: 215 Summit Street (Number) Galena (City) 61036 (Zip Code)

County: Jo Davies

Telephone Number: (815) 776-1340 **Fax #** (815) 776-7274

HFS ID Number:

Date of Initial License for Current Owners: 01-01-70

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 20-4560540

In the event there are further questions about this report, please contact:
Name: Tracy Bauer **Telephone Number:** (815) 776-1340
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2011 to 9/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Tracy Bauer
(Title) Chief Executive Officer

Paid Preparer
(Signed) See Opinion Letter
(Date)
(Print Name and Title) Holly S. Pokrandt, CPA, Partner
(Firm Name & Address) Wipfli LLP, 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701
(Telephone) (715) 858-6627 Fax # (715)-832-2345

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,862	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		7,530	381	7,911	8
9	SNF/PED					9
10	ICF	10,269			10,269	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,269	7,530	381	18,180	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.14%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 5 and days of care provided 381

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: 09/30/2012

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	109,438		3,533	112,971	(6,387)	106,584		106,584			1
2	Food Purchase		167,914		167,914		167,914		167,914			2
3	Housekeeping	48,661		120	48,781		48,781		48,781			3
4	Laundry			37,577	37,577		37,577		37,577			4
5	Heat and Other Utilities			25,100	25,100		25,100		25,100			5
6	Maintenance	23,598		26,691	50,289		50,289		50,289			6
7	Other (specify):*											7
8	TOTAL General Services	181,697	167,914	93,021	442,632	(6,387)	436,245		436,245			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,129,200		40,865	1,170,065		1,170,065		1,170,065			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Incontinent Supplies		18,242		18,242		18,242		18,242			15
16	TOTAL Health Care and Programs	1,129,200	18,242	40,865	1,188,307		1,188,307		1,188,307			16
	C. General Administration											
17	Administrative	23,321		69,383	92,704		92,704		92,704			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	4,409		13,116	17,525		17,525		17,525			21
22	Employee Benefits & Payroll Taxes			289,546	289,546	6,387	295,933		295,933			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			22,926	22,926		22,926		22,926			26
27	Other (specify):*											27
28	TOTAL General Administration	27,730		394,971	422,701	6,387	429,088		429,088			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,338,627	186,156	528,857	2,053,640		2,053,640		2,053,640			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Galena Stauss Nursing Home #0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,248	59,248	38,605	97,853		97,853			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					41,524	41,524		41,524			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* A & G Allocation			80,129	80,129	(80,129)						36
37	TOTAL Ownership			139,377	139,377		139,377		139,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	13,415			13,415		13,415		13,415			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,228	45,228		45,228		45,228			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	13,415		45,228	58,643		58,643		58,643			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,352,042	186,156	713,462	2,251,660		2,251,660		2,251,660			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Galena Stauss Nursing Home

ID# 0049718

Report Period Beginning: 10/01/2011

Ending: 9/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Galena Stauss Nursing Home **#** 0049718 **Report Period Beginning:** 10/01/2011 **Ending:** 9/30/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Galena Stauss Nursing Home **#** 0049718 **Report Period Beginning:** 10/01/2011 **Ending:** 9/30/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	2007 Bonds		X	Construction of New Hospital		10/1/06	$ 45,485,000	$ 45,485,000	10/1/2046	6.7500	$ 41,524	1
2				Administration is located in								2
3				new facility - this portion								3
4				relates to the NH's portion								4
5				of the administrative offices.								5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 45,485,000	$ 45,485,000			$ 41,524	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 45,485,000	$ 45,485,000			$ 41,524	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Galena Stauss Nursing Home COUNTY Jo Davies

FACILITY IDPH LICENSE NUMBER 0049718

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,191 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		1962	1962	$ 140,184	$	47	$	$	$ 140,184	4
5				1971	172,403		41			172,403	5
6				1981	57,843		Various			57,843	6
7				1988	171,479	14,538	Various	14,538		104,673	7
8				2007	899,373	38,605	Various	38,605		187,735	8
	Improvement Type**										
9	VARIOUS ADDITIONS			04/01/68	2,826.92		07 00			2,826.92	9
10	VAR. ADD.			04/01/69	62.76		07 00			62.76	10
11	VAR. ADD			04/01/71	7,133.60		07 00			7,133.60	11
12	VAR. ADD.			04/01/72	229.07		15 00			229.07	12
13	VAR. ADD.			04/01/73	151.24		10 00			151.24	13
14	CURB.GUTTER&SDWLK-FRONT ENT			04/01/81	1,002.61		12 00			1,002.61	14
15	PARKING LOT EXPAN.			04/01/81	7,150.22		12 00			7,150.22	15
16	LANDSCAPING-HARMS			04/01/83	488.93		10 00			488.93	16
17	GRAVEL PARKING LOT			04/01/88	3,096.42		05 00			3,096.42	17
18	SIDEWALK			04/01/88	184.69		10 00			184.69	18
19	FENCE AROUND CHILLER			04/01/89	225.81		15 00			225.81	19
20	SIDEWALKS & CEMENT SLAB			04/01/89	801.34		15 00			801.34	20
21	CHAIN LINK FENCE			04/01/89	330.28		15 00			330.28	21
22	CONCRETE PARKING LOT			04/01/89	1,375.77		15 00			1,375.77	22
23	GAZEBO			04/01/89	1,281.54		15 00			1,281.54	23
24	SIDEWALKS-SPROULE			04/01/90	716.15		15 00			716.15	24
25	LANDSCAPING			03/31/04	1,209.36	120.94	10 00	120.94		1,027.95	25
26	CONCRETE DRIVEWAY			04/01/91	719.54		15 00			719.54	26
27	LANDSCAPING COURTYARD			04/01/91	1,261.18		10 00			1,261.18	27
28	PAVE PARKING LOT			04/01/94	1,901.95		12 00			1,901.95	28
29	PHYSICAL THERAPY/HELIO PAD			04/01/95	2,284.15		08 00			2,284.15	29
30	14 CAR BUMPERS			04/01/96	222.38		05 00			222.38	30
31	PARKING LOT			06/01/00	25,238.72	1,682.58	15 00	1,682.58		20,681.73	31
32	CEDAR PRIVACY FENCE			04/01/01	1,884.61		08 00			1,884.61	32
33	132 SHRUBS			03/01/02	1,421.00		05 00			1,421.00	33
34	LANDSCAPING			03/31/02	929.11	46.46	10 00	46.46		929.11	34
35	2 TREES			03/31/02	131.92	6.60	20 00	6.60		69.26	35
36	WOODEN FENCE AROUND HVAC			03/31/02	592.52		08 00			592.52	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	MOVING/FLATING OF BACKFILL	03/31/02	$ 1,703.69	$	05 00	$	$	$ 1,703.69	37
38	HANDICAP ENTRANCE	03/31/02	738.77	49.25	15 00	49.25		517.15	38
39	REPAIR TO SIDEWALK (CLINIC/NH)	03/31/02	1,135.67	75.71	15 00	75.71		794.98	39
40	MOVING/FLATTENING OF BACKFILL	11/29/02	373.15		05 00			373.15	40
41	TWO BRONZE PLAQUES	03/20/03	324.15	32.42	10 00	32.42		307.95	41
42	SHRUBS/LANDCAPING/MULCHING	06/05/03	1,672.03	167.20	10 00	167.20		1,588.43	42
43	RESURFACE PARKING LOT	07/08/03	1,391.97	116.00	12 00	116.00		1,101.98	43
44	LANDSCAPING/SHRUBS/MULCH	07/23/03	406.32	40.63	10 00	40.63		386.01	44
45	PARKING LOT	07/25/05	2,848.40	356.05	08 00	356.05		2,670.39	45
46	LANDSCAPING & PARKING LOT	06/01/00	39,207.46	2,613.83	15 00	2,613.83		32,128.35	46
47	9 SHRUBS	03/31/02	98.38		05 00			98.38	47
48	2 TREES	03/31/02	75.38	3.77	20 00	3.77		39.58	48
49	LANDSCAPING	03/31/02	538.25	26.91	10 00	26.91		538.25	49
50	MULCH	03/31/02	63.64	3.20	10 00	3.20		63.64	50
51	BULLET EDGING	07/31/03	263.85		05 00			263.85	51
52	LANDSCAPING	07/31/03	1,185.42	118.54	10 00	118.54		1,126.15	52
53	SHRUBS	07/31/03	1,377.65		05 00			1,377.65	53
54	VARIOUS ADDITIONS	04/01/62	9,558.00		30 00			9,558.00	54
55	VAR. ADD.	04/01/69	471.15		20 00			471.15	55
56	STOREROOM	04/01/70	11,786.36		42 00			11,786.36	56
57	AIR CONDITIONING	04/01/70	5,136.70		20 00			5,136.70	57
58	AIR CONDITIONING	04/01/74	6,323.55		20 00			6,323.55	58
59	VARIOUS ADDITIONS	04/01/74	1,316.62		35 00			1,316.62	59
60	STOREROOM & MTC-GENERAL	04/01/75	35,866.93		34 00			35,866.93	60
61	STOREROOM & MTC-ELECTRICAL	04/01/75	3,824.97		20 00			3,824.97	61
62	STOREROOM & MTC-MECHANICAL	04/01/75	8,221.55		25 00			8,221.55	62
63	STOREROOM & MTC-SPRINKLER	04/01/75	1,481.30		25 00			1,481.30	63
64	VARIOUS ADDITIONS	04/01/75	111.19		25 00			111.19	64
65	ELECTRICAL 1975 ADDN	04/01/77	267.56		18 00			267.56	65
66	STORM WINDOWS & SCREENS-1962	04/01/77	1,030.51		32 00			1,030.51	66
67	REMODEL X-RAY ROOM	04/01/81	11,234.57		28 00			11,234.57	67
68	HEATING,VENTING,& AIR COND	04/01/82	1,149.61		08 00			1,149.61	68
69	INSULATION	04/01/82	5,661.00		15 00			5,661.00	69
70	**TOTAL (lines 4 thru 69)**		**$ 1,662,982**	**$ 58,603**		**$ 58,603**	**$**	**$ 871,412**	70

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,662,982	$ 58,603		$ 58,603	$	$ 871,412	1
2	ENCLOSED PORCH PATIO	04/01/82	2,974.52		15 00			2,974.52	2
3	RENOVATION OF C.S. AREA	04/01/83	1,066.69		20 00			1,066.69	3
4	LIGHT FIXTURES	04/01/84	529.49		10 00			529.49	4
5	VINYL WALL COVERING	04/01/84	3,975.40		10 00			3,975.40	5
6	224 CORRIDOR HANDRAIL	04/01/84	1,435.32		25 00			1,435.32	6
7	DIETARY REMODELING	04/01/84	1,384.42		25 00			1,384.42	7
8	MEDICAL RECORDS REMODELING	04/01/84	603.08		25 00			603.08	8
9	ELECTRICAL WORK	04/01/85	274.99		20 00			274.99	9
10	REMOTE THERMOSTATS	04/01/85	1,586.84		20 00			1,586.84	10
11	WALL COVERINGS	04/01/85	3,768.85		10 00			3,768.85	11
12	GENERAL CONTRACT	04/01/85	32,279.96		24 00			32,279.96	12
13	ELECTRICAL	04/01/85	19,622.56		20 00			19,622.56	13
14	MECHANICAL	04/01/85	29,727.96		20 00			29,727.96	14
15	MILLWORK	04/01/85	11,687.32		20 00			11,687.32	15
16	FLOORING	04/01/85	3,846.53		05 00			3,846.53	16
17	PAINTING	04/01/85	6,442.82		05 00			6,442.82	17
18	NEW ROOM-GIESE	04/01/86	11,425.65		10 00			11,425.65	18
19	REMODELING-NURSERY	04/01/86	222.87		10 00			222.87	19
20	PAINTING-TIEGS	04/01/87	1,551.04		05 00			1,551.04	20
21	12-NEW WINDOWS-GREENCO	04/01/87	3,873.25		12 00			3,873.25	21
22	ROOF REPLACEMENT	04/01/88	1,089.95		10 00			1,089.95	22
23	REMODELING-OLD N.H.	04/01/88	1,307.80		20 00			1,307.80	23
24	FLOOR COVERINGS-BLDG ADD'N	05/01/88	3,859.43		10 00			3,859.43	24
25	PAINTING-BLDG ADD'N	05/01/88	7,643.94		05 00			7,643.94	25
26	MILLWORK-BLDG ADD'N	05/01/88	5,951.75		20 00			5,926.90	26
27	PLUMBING-BLDG ADD'N	05/01/88	24,989.09		20 00			24,884.92	27
28	HEATING & A/C-BLDG ADD'N	05/01/88	24,437.12		20 00			24,335.26	28
29	ELECTRICAL-BLDG ADD'N	05/01/88	29,352.17		20 00			29,229.85	29
30	FIRE ALARM SYSTEM	04/01/89	9,341.71		15 00			9,341.71	30
31	AIR CONDITIONING REPLACEMENT	04/01/89	8,507.01		10 00			8,507.01	31
32	BOILER REPLACEMENT	04/01/89	21,148.21		20 00			21,148.21	32
33	INSULATION	04/01/90	947.65		10 00			947.65	33
34	**TOTAL (lines 1 thru 33)**		$ 1,939,837	$ 58,603		$ 58,603	$	$ 1,147,914	34

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,939,837	$ 58,603		$ 58,603	$	$ 1,147,914	1
2	NEW DOORS-GREENCO	04/01/90	2,740.43		15 00			2,740.43	2
3	PAINTING-STRUB	04/01/90	601.19		05 00			601.19	3
4	DOOR ALARM SYSTEM	04/01/91	750.24		15 00			750.24	4
5	REMODELING-N.H.	04/01/92	536.10		10 00			536.10	5
6	GARAGE DOOR	04/01/92	513.37		10 00			513.37	6
7	REMODELING-N.H.	04/01/94	2,880.70	144.04	20 00	144.04		2,664.69	7
8	NEW ROOF-GIESE	04/01/94	2,767.36		10 00			2,767.36	8
9	NEW ROOF	04/01/96	20,693.26		10 00			20,693.26	9
10	DRAIN LINE UNDER FLOOR	04/01/96	1,819.16		10 00			1,819.16	10
11	ELECTRICAL-RADIOLOGY REMODEL	04/01/96	13,501.36	750.08	18 00	750.08		12,376.24	11
12	GENERAL-RADIOLOGY REMODELING	04/01/96	31,215.38	1,560.77	20 00	1,560.77		25,752.66	12
13	HELIPORT LIGHTING	04/01/96	1,511.46		15 00			1,511.46	13
14	ROOF IMPROVEMENT	04/01/97	855.61		10 00			855.61	14
15	PHYSICAL THERAPY ROOM REMODEL	04/01/97	4,169.28	208.46	20 00	208.46		3,231.20	15
16	HEATING AND A/C UNITS	04/01/99	1,649.24		10 00			1,649.24	16
17	2 STANLEY MAGIC AUTOMATIC DOORS	04/01/99	1,221.23		10 00			1,221.23	17
18	REBUILD CHILLER	04/01/99	3,665.45		10 00			3,665.45	18
19	FIRE ALARM IMPROVEMENTS	04/01/00	1,375.77		10 00			1,375.77	19
20	ARMSTRONG TILE FLOORING FOR DIETARY	04/01/00	1,287.19	64.36	20 00	64.36		804.50	20
21	FIRE ALARM SYSTEM-ADMINISTRATION	04/01/01	904.61	60.31	15 00	60.31		693.54	21
22	REMODELING-BUSINESS OFFICE	04/01/01	63,450.62	4,230.04	15 00	4,230.04		48,645.47	22
23	HOOD & EXHAUST WORK - DIETARY	04/01/01	906.50	45.32	20 00	45.32		521.24	23
24	RADIOLOGY REMODEL	03/31/02	23,994.87	1,599.66	15 00	1,599.66		16,796.41	24
25	NURSING HOME NEW CEILING	03/31/02	2,788.47	139.42	10 00	139.42		2,788.47	25
26	NURSING HOME SHOWER FLOORS	03/31/02	471.15	23.56	20 00	23.56		247.36	26
27	CARPET-HALLWAY	03/31/02	5,451.05		05 00			5,451.05	27
28	NURSING HOME REMODEL	11/04/02	3,088.20	308.82	10 00	308.82		2,933.79	28
29	NURSING HOME CARPET	11/20/02	4,742.06		05 00			4,742.06	29
30	NURSING HOME THERMOSTATS & ELECTRIC	01/09/03	2,427.52	242.75	10 00	242.75		2,306.15	30
31	AUTOMATIC ENTRANCE MED-SURG	01/28/03	7,500.75		05 00			7,500.75	31
32	ADMINISTRATION REMODEL	03/26/03	5,490.44	366.03	15 00	366.03		3,477.28	32
33	NURSING HOME FIRE DOOR	03/31/03	1,309.81	130.98	10 00	130.98		1,244.31	33
34	**TOTAL (lines 1 thru 33)**		**$ 2,156,117**	**$ 68,478**		**$ 68,478**	**$**	**$ 1,330,791**	34

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,156,117	$ 68,478		$ 68,478	$	$ 1,330,791	1
2	HOSPITAL GENERATOR POWER SOURCE	03/31/03	4,989.70		05 00			4,989.70	2
3	ELECTRICAL WORK	10/31/03	3,736.05	186.80	20 00	186.80		1,587.82	3
4	WATER HEATERS	10/31/03	844.34	84.43	10 00	84.43		717.69	4
5	FLOORING	10/31/03	927.34		05 00			927.34	5
6	DENSITOMETER ROOM	03/31/04	4,102.37		05 00			4,102.37	6
7	CIRCULATING BOOSTER PUMP	04/30/04	2,708.19	270.82	10 00	270.82		2,301.96	7
8	PT REMODEL	05/01/04	8,043.91	536.26	15 00	536.26		4,558.23	8
9	AUTOMATIC DOOR	07/01/04	778.34	77.83	10 00	77.83		661.59	9
10	CT REMODEL	05/20/05	58,449.96	2,922.50	20 00	2,922.50		21,918.73	10
11	CARPET-EDUCATION ROOM	07/19/05	463.61		05 00			463.61	11
12	WOOD FLOORING-DINING ROOMS	07/19/05	781.17	78.12	10 00	78.12		585.88	12
13	MAMMOGRAM ROOM REMODEL	08/30/05	3,430.37	228.69	15 00	228.69		1,715.18	13
14	REMODELING-GENERAL	04/01/94	52,849.58	1,957.39	27 00	1,957.39		36,211.75	14
15	PLUMBING	04/01/94	4,680.12	234.00	20 00	234.00		4,329.09	15
16	HEATING,VENTING,AIR COND.	04/01/94	11,049.06	552.46	20 00	552.46		10,220.42	16
17	ELECTRICAL	04/01/94	21,536.50	1,076.83	20 00	1,076.83		19,921.28	17
18	PAINTING	04/01/94	649.96		10 00			649.96	18
19	SUSPENDED CEILING	04/01/94	2,919.13		12 00			2,919.13	19
20	CABINETS	04/01/94	7,331.93	366.60	20 00	366.60		6,782.07	20
21	FLOOR COVERINGS	04/01/94	4,840.01		10 00			4,840.01	21
22	ELEVATOR	04/01/94	11,875.62	593.78	20 00	593.78		10,984.94	22
23	HAND RAIL FOR PHYSICAL THERAPY	12/17/02	303.05	20.20	15 00	20.20		191.93	23
24	EXTENSION JOINT	11/03/04	530.02		05 00			530.02	24
25	ELEVATOR PROCESSOR BOARD	12/01/05	980.55		05 00			972.38	25
26	ER REMODEL/SHOWER ROOM	01/01/06	1,670.97	111.40	15 00	111.40		747.31	26
27	GARAGE DOOR	07/01/06	436.17	43.62	10 00	43.62		270.79	27
28	FLOORING	09/22/06	232.75	23.27	10 00	23.27		151.29	28
29	HEATING	09/30/07	2,125.84	141.72	15 00	141.72		779.48	29
30	SPRINKLER SYSTEM	09/30/07	22,633.43	905.34	25 00	905.34		4,979.35	30
31	SPRINKLER SYSTEM	09/30/07	2,220.07	88.80	25 00	88.80		488.42	31
32	HVAC UNIT	09/30/07	7,043.55	469.57	15 00	469.57		2,582.63	32
33	PLASTIC CULVERT PIPE	09/30/07	1,470.00	73.50	20 00	73.50		404.25	33
34	**TOTAL (lines 1 thru 33)**		**$ 2,402,750**	**$ 79,522**		**$ 79,522**	**$**	**$ 1,484,278**	34

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,402,750	$ 79,522		$ 79,522	$	$ 1,484,278	1
2	Building Components/Remodeling - 2007 Nursing Home	12/05/07	1,380.48	69.03	20 00	69.03		333.63	2
3	Deck	09/30/10	4,997.61	499.76	10 00	499.76		1,249.40	3
4	Flooring	09/30/10	420.49	42.05	10 00	42.05		105.12	4
5	Windows and Doors	09/30/10	5,307.07	265.35	20 00	265.35		663.38	5
6	Landscaping	12/02/11	738.47	52.75	07 00	52.75		52.75	6
7	Replace Flat Roof at NH	10/24/11	48,498.60	2,424.93	10 00	2,424.93		2,424.93	7
8	Replace Kitchen Ceiling	11/16/11	2,357.65	117.88	10 00	117.88		117.88	8
9	Carpet Flooring	07/13/12	6,801.56	680.16	05 00	680.16		680.16	9
10	Flooring - Vinyl	07/13/12	3,891.72	194.59	10 00	194.59		194.59	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,477,144	$ 83,868		$ 83,868	$	$ 1,490,100	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 122,675	$ 8,993	$ 8,993	$		$ 94,189	71
72	Current Year Purchases	2,924	319	319			319	72
73	Fully Depreciated Assets	394,891	4,673	4,673			394,891	73
74								74
75	TOTALS	$ 520,490	$ 13,985	$ 13,985	$		$ 489,399	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,997,634	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,853	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 97,853	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,979,499	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	line 39 col 4	hrs	13,415					13,415	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 13,415		$	$		$ 13,415	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/2012 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,610,105	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,549,675)	3,269,698		3
4	Supply Inventory (priced at Cost)	369,055		4
5	Short-Term Investments	1,884,929		5
6	Prepaid Insurance	58,880		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,192,667	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,997,638		12
13	Land	559,916		13
14	Buildings, at Historical Cost	42,881,259		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,060,333		16
17	Accumulated Depreciation (book methods)	(19,382,603)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,059		21
22	Other Long-Term Assets (spe Intangibles	3,256		22
23	Other(specify): Bond issuance costs	818,398		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,942,256	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 47,134,923	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 796,574	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	720,000		29
30	Accrued Salaries Payable	446,734		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,534,929		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security deposits held	96,113		36
37	Amounts payable to Medicare	1,806,260		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,400,610	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	44,765,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 44,765,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 50,165,610	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,030,687)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 47,134,923	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,506,608)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,506,608)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,521,166)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Temp restricted contributions and income	5,610	15
16	Other (describe) Loans forgiven from Temp Restricted Net Ass	(8,523)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,524,079)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,030,687)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,570,237	1
2	Discounts and Allowances for all Levels	(944,367)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,625,870	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,731	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,731	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,681,601	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	442,632	31
32	Health Care	1,188,307	32
33	General Administration	422,701	33
	B. Capital Expense		
34	Ownership	139,377	34
	C. Ancillary Expense		
35	Special Cost Centers	13,415	35
36	Provider Participation Fee	45,228	36
	D. Other Expenses (specify):		
37	Hospital Net Loss	1,936,549	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,188,209	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,506,608)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,506,608)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,296,586	44
45	Private Pay - Net Inpatient Revenue	1,456,397	45
46	Medicare - Net Inpatient Revenue	118,518	46
47	Other-(specify) Medicare contractuals related to hosp ancillaries	(245,631)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,625,870	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,950	2,873	$ 53,056	$ 18.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,502	6,337	159,382	25.15	3
4	Licensed Practical Nurses	11,118	10,837	210,803	19.45	4
5	CNAs & Orderlies	49,432	48,180	599,900	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,666	3,573	34,483	9.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,528	9,085	109,438	12.05	15
16	Dishwashers					16
17	Maintenance Workers	1,507	1,479	23,598	15.96	17
18	Housekeepers	4,542	4,457	48,661	10.92	18
19	Laundry					19
20	Administrator	1,663	1,621	46,518	28.70	20
21	Assistant Administrator					21
22	Other Administrative	249	244	27,730	113.65	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8	8	83	10.38	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	2,138	2,084	24,975	11.98	33
34	TOTAL (lines 1 - 33)	93,303	90,778	$ 1,338,627 *	$ 14.75	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tracy Bauer	CEO		$ 23,321
Peggy Stockel	NH Admin/DON		
Hesper Nowatski	NH Admin/DON		
(Amounts are allocated - see separate cost report schedules)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 23,321

B. Administrative - Other

Description	Amount
Supplies and Allocated administrative expenses	$ 69,383
TOTAL (agree to Schedule V, line 17, col. 3)	$ 69,383
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Allocated Benefits from Medicare Cost Report	289,546
TOTAL (agree to Schedule V, line 22, col.8)	$ 289,546

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home **#** 0049718 **Report Period Beginning:** 10/01/2011 **Ending:** 9/30/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,661** Line **15**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **45,228**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,387** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **57,770**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N.A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N.A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N.A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wipfli LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.